(3) Even though the maximum allowable fee rate when computed on the basis of twenty-two (22) cents per mile plus four (4) dollars for waiting time would not equal the six (6) dollars or ten (10) dollars allowable amounts, the higher amount is paid to encourage private automobile carriers to provide necessary medical transportation. Additionally, nothing in this section requires the department to pay the amounts specified if the private automobile carrier expresses a preference for reimbursement in a lesser amount; then the lesser amount shall be paid. Toll charges shall be reimbursable when presented with a receipt.

(4) Waiting time shall be a reimbursable component of the private automobile carrier transportation fee only if waiting time occurs. If waiting time occurs due to admittance of the recipient into the medical institution, the private automobile carrier may be reimbursed for the return trip to the point of recipient pick-up as though the recipient were in the vehicle; that is, the total reimbursable amount shall be computed on the basis of the maximum allowable fee or mileage rate plus waiting time. Waiting time shall not be paid for the attendant or caretaker relative (e.g., mother, father) who is accompanying the recipient and not personally being transported for Medicaid covered service.

(5) If a private automobile carrier is transporting more than one (1) recipient, only one (1) mileage payment shall be allowed. Mileage shall be computed on the basis of the distance between the most remote recipient and the most remote medical service utilized; and will include any necessary additional mileage to pickup and discharge the additional recipients.

D. Non-Commercial Group Carriers.

(1) The department shall reimburse participating non-commercial group carriers based on actual reasonable, allowable cost to the provider based on cost data submitted to the department by the provider.

(2) The minimum rate shall be twenty (20) cents per recipient per mile transported and the rate upper limit shall be fifty (50) cents per recipient per mile transported.

(3) Payment for a parent or other attendant shall be at the usual recipient rate.

E. Specialty Carriers.

(1) Participating specialty carriers shall be reimbursed at the lesser of the following rates:

(a) The actual charge for the service; or

(b) The usual and customary charge for that service by the carrier, as shown in the schedule of usual and customary charges submitted by the carrier to the department; or

(c) The program maximum established for the service.

(2) Program maximums shall be:

(a) For nonambulatory recipients who require the use of a wheelchair, the upper limit shall be twenty-five (25) dollars for the first recipient plus four (4) dollars for each additional nonambulatory recipient transported on the same trip, for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollar and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and certified; mileage charges shall not be allowed for additional recipients.

(b) For ambulatory recipients who are disoriented, the upper limit shall be twelve (12) dollars and fifty (50) cents for the first recipient plus four (4) dollars for each additional disoriented recipient transported on the same trip for each time a recipient is transported to or transported from the medical service site. To this base rate shall be added one (1) dollars and fifty (50) cents per loaded mile for the first recipient for miles the recipient is transported, and toll charges actually incurred and verified; mileage charges shall not be allowed for additional recipients.

(c) For both paragraphs (a) and (b) of this section, empty vehicle miles shall not be included when computing allowable reimbursement for mileage.

(3) Reimbursement shall be made at specialty carrier rates for the following types of recipients only:

(a) Nonambulatory recipients who need to be transported by wheelchair, but shall not include recipients who need to be transported as stretcher patients; and

(b) Ambulatory recipients who are disoriented.

(4) The specialty carrier shall obtain a statement from the recipient's physician (or, if the recipient is in a nursing facility, from the director of nursing, charge nurse, or medical director in lieu of physician) to verify that transportation by the specialty carrier is medically necessary due to the recipient's nonambulatory or disoriented condition. Claims for payment which are submitted without the required statement of verification shall not be paid.

F. Specially authorized transportation services authorized in unforeseen circumstances may be paid for at a rate adequate to secure the necessary service; the amount allowed shall not exceed the usual and customary charge of the provider. The Department for Medicaid Services shall review and approve or disapprove requests for specially authorized transportation services based on medical necessity.

G. Use of flat rates.

Transportation payment shall not exceed the lesser of six (6) dollars per trip, one (1) way (or twelve (12) dollars for a round trip), or the usual fee for the participating transportation provider computed in the usual manner if:

(1) The recipient chooses to use a medical provider outside the medical service area; and

(2) The medical service is available in the recipient's medical service area; and

(3) The recipient has not been appropriately referred by the medical provider within his medical service area.

H. Meals and Lodging.

The flat rate for meals and lodgings for recipients and attendants when preauthorized (or post-authorized if appropriate) by the department shall be as follows:

(1) Standard Area:

(a) Meals: breakfast-$4 per day; lunch-$5 per day; dinner-$11 per day; and

(b) Lodgings: $40 per day

(2) High Rate Area:

(a) Meals: breakfast-$5 per day; lunch-$6 per day; dinner-$15 per day; and

(b) Lodgings: $55 per day.

I. Limitations.

(1) Any reimbursement for medical transportation shall be contingent upon the recipient receiving the appropriate preauthorization or postauthorization for medical transportation as required by the Department for Medicaid Services.

(2) (a) Authorization shall not be granted for recipients transported for purposes other than to take the recipient to or from covered Medicaid services being provided to that recipient, except in the instance of one (1) parent accompanying a child to or from covered medical services being provided to the child or if one (1) attendant is authorized for a recipient traveling to or from covered medical services based on medical condition of the recipient.

(b) Reimbursement shall be limited to transportation services and shall not include the services, salary or time of the attendant or parent.

(3) An individual who owns a taxi company and who uses the taxi as his personal vehicle shall be reimbursed at the private auto rate when transporting household family members.

(4) Mileage for reimbursement purposes shall be computed by the most direct accessible route from point of pickup to point of delivery.

VIII. Outpatient Hospital Services

1. Payment for outpatient hospital services provided on or after July 1, 1990 shall be made at the rate of sixty-five (65) percent of usual and customary charges billed to the Medicaid Program with a settlement (except for out-of-state hospitals) to the lower of cost or charges at the year end, not to exceed the upper limits for payment as defined at 42 CFR 447.321.
2. Charges or costs shall not be transferred between the inpatient and outpatient service units.

3. Laboratory services shall be paid based on the medicare allowable payment rates. For laboratory services with no established allowable payment rate, the payment shall be based on 65 percent of the usual and cutomary actual billed charges with no settlement to cost.

X. Home Health Agency Services

(1) A. Home Health agencies shall be reimbursed on the basis of interim rates set by the Medicaid agency using available Medicaid data as applied to Medicaid covered services taking into consideration the upper limit shown below. Payments made at the interim rate (except for incentive payments) will be settled back to actual cost at the end of the facility's fiscal year with actual allowable costs not to exceed the amounts that would be allowable taking into consideration the upper limit. The Medicaid final rates (except for incentive payments) may not exceed federally established upper limits for Medicare. Effective July 1, 1989, a home health agency (but not including a publicly operated agency) whose non-aggregated base year costs (as shown in the cost report used to set the agency's interim rate) are below the prospective upper limit for the agency shall receive a cost containment incentive payment. The incentive payment will bear an inverse relationship to the projected current year basic per visit cost in order to provide a greater return for those agencies able to provide the required level of care at a lower per visit cost. The incentive payment will be reviewed and adjusted July 1 of each year. The incentive payment schedule is as follows:

| Percentage of Per unit Cost to Upper Limit | Incentive Payment Per Visit Amount |
|---|---|
| 95.01% - 100% | -- |
| 90.01% - 95% | $1.00 |
| 85.01% - 90% | 1.50 |
| 80.01% - 85% | 2.00 |
| 80% and Below | 2.50 |

Publicly operated home health agencies will be reimbursed at full allowable cost but are subject to Medicare upper limits. Payments for agencies other than publicly operated home health agencies (except the rate add-ons to recognize provider taxes, skilled nursing cost center, and disposable medical supplies) may not exceed a prospective upper limit which will be set at 105 percent of the weighted median of the array of allowable per visit costs of these agencies that will be subject to the upper limit. Facilities shall be placed in an urban or rural array based on the facility location for the following cost centers or disciplines: speech pathology, physical therapy, occupational therapy, medical social services, and home health aid services.

The upper limit for the skilled nursing cost center shall be the Medicare upper limit. A determination as to whether a county is urban or rural will be made taking into account usual standard metropolitan statistical areas. The arrays shall be based on

annual cost report data with costs trended through June 30 and indexed for the rate year; the rate year shall begin on July 1, and end on June 30; and the upper limit shall be subject to an annual adjustment to be effective on July 1 of each rate year. Aggregation of costs (i.e., shifting of allowable costs from one cost center to another if the limit is exceeded in one cost center but not in another) will be permitted. The array shall be based on the latest available cost report as of May 31 preceding the rate year.

A home health agency will be reimbursed for durable medical equipment (DME) or appliances only if the agency signs a DME provider participation agreement.

The agency will continue to be reimbursed for disposable medical supplies without regard to whether the agency participates as a DME provider. Disposable medical supplies shall be reimbursed on a interim basis at a percent of allowable billed charges with a settlement to actual cost at the end of the agency's fiscal year.

New home health agencies shall be paid seventy (70) percent of the Title XIX maximum rate not to exceed Medicare upper limits until a fiscal year end cost report is available.

Provider taxes shall be considered allowable costs; for the rate period beginning on July 1, 1993 and ending on June 30, 1994, the cost of the provider tax shall be added to the rate as an add-on. For subsequent rate periods, the provider tax cost shall be shown in the appropriate cost report used for rate-setting.

B. Out-of-State Home Health agencies.

The Cabinet shall reimburse participating out-of-state home health agencies at the lower of the Title XVIII maximum payment rate, the Title XIX maximum payment rate or the agency's usual and customary actual billed charge. For these out-of-state agencies, disposable medical supplies shall be reimbursed at a rate of eighty (80) percent of the usual and customary actual billed charge.

(2) Limitations of Allowable Cost

A. Owner's Compensation Limits

Compensation to owners will be considered an allowable cost provided that it is reasonable and that the services actually perform are a necessary function.

An owner, for the purposes of the payment system, is defined as any person and related family members (as specified below) with a cumulative ownership interest of 5 percent or more. Members of the immediate family of an owner, including husband, wife, father, mother, brothers, sisters, sons, daughter, aunts, uncles, and in-laws, will be treated as owners for the purpose of compensation.

Compensation includes total benefit received by the owner for the services he provides to the agency, except that board of director's fees received by the owner are not to be considered in determining compensation limitations.

The term "necessary function" is defined to mean that had the owner not rendered services pertinent to the operation of the agency, the facility would have had to employ another person to perform the service.

The cost of full-time owner-employees may be included as an allowable cost if the compensation is reasonably comparable to compensation for similar positions in the industry, but may not exceed the applicable compensation limit for an owner-administrator.

The compensation of part-time owner-employees performing managerial type functions is allowable to the extent that the compensation does not exceed the percent of time worked times eighty (80) percent of the applicable compensation limits for an owner-administrator.

Full-time owner-administrators and full-time owner-employees who perform non-managerial functions in agencies other than the agency with which they are primarily associated shall, for Program purposes, be limited to reasonable compensation for not more than fourteen hours per week in addition to the salary in the agency with which they are primarily associated. To be considered reasonable compensation, the owner must prove performance of a necessary function and be able to document the time claimed for compensation. When managerial functions are performed in a non-primary agency by the full-time owner-administrator or full-time owner-employee of another agency, the cost of such services will be non-allowable for purposes of the Program.

Fringe benefits routinely provided to all employees and the owner-administrator will not be considered a part of owner's compensation.

Reasonableness of compensation for an owner-administrator will be $43,200 per year. This limit will apply to both urban and rural agencies and will be increased on July 1 of each year by the inflation factor index for wages and salaries of the Home Health Agency Market Basket of Operating Costs as indicated by the National Forecasts supplied by Data Resources, Inc.

B. Other Limits on Allowable Cost

(1) BOARD OF DIRECTORS' FEES. The cost of Board of Directors' fees will be limited to five (5) meetings annually for single facility organizations and twelve (12) meetings annually for multiple facility organizations. The allowable fee will be limited to two hundred dollars ($200) per Director per meeting. The limit on the cost for Board meetings is intended to cover all costs associated with these meetings and not just the fee paid to the Board Member. No payment is allowed for any Board Member not in attendance. Costs in excess of these limits will be deemed to be unallowable.

(2) PRIVATE CLUB MEMBERSHIPS. The costs associated with private club memberships (dues, initiation fees and assessments) will be excluded from allowable costs.

(3) MOTOR VEHICLES. Expenses related to motor vehicles are allowed to the extent that they are documented for business use which is related to patient care. This includes the costs associated with facility owned vehicles and mileage allowances (not to exceed the mileage allowance allowed for Federal Income Tax purposes). It is the responsibility of the facility to maintain sufficient documentation (mileage logs for facility vehicles and expense reports for mileage allowances) to verify the business use of the vehicles. Costs associated with the personal use of motor vehicles is considered unallowable for purposes of Medicaid reimbursement. This includes expense. However, if the value of the personal use of a facility owned vehicle is included in the employee's W-2 statement or reported on a form 1099 in accordance with Internal Revenue Service regulations, the personal use of the vehicle will be deemed as compensation and allowable to the extent that total compensation does not exceed the owners' compensation limitations in the case of owners. In the case of non-owners the total compensation package is subject to an overall test of reasonableness.

(4) POLITICAL CONTRIBUTIONS AND LEGAL FEES. The costs associated with political contributions and legal fees not related to patient care will be excluded from allowable costs. The following are examples of legal fees not related to patient care, this list is not all

inclusive: legal fees incurred in attempts to block the approval of a Certificate of Need for another Home Health Agency; legal fees associated with the acquisition of another agency; or legal fees resulting from the commission of an illegal act by the agency, its owners or its agents. Legal fees relating to lawsuits against the Cabinet will be included as reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or when otherwise agreed to by the parties involved or ordered by the court.

(5) TRAVEL EXPENSES. The cost of travel and associated expenses of conventions, meetings, assemblies, conferences, and activities unrelated to the educational needs of the agency owners, directors and staff are not allowable expense. However, the cost for training and associated travel (meals, lodging and transportation expenses) are allowable if the cost is reasonable and necessary, and it is incurred in the forty-eight (48) contiguous United States. The reasonable and necessary test will take into account items such as: the number of trips taken; the expense associated with each trip; the number of persons attending each function; and the appropriateness of the training.